CATAWBA COUNTY INJURY/EXPOSURE REPORT

Facts Regarding Injury/Exposure: to be filled out by Employee

Date Report Initiated _____

County Department Involved _____

Injured Information

Name of Inured (Last, First, Middle) | Date of Birth

Home Address

County | SS# | Marital Status | # of Dependents

Home Phone | Work Phone | Sex | Height | Weight | Time Work Began AM/PM

Work Schedule | F/T ☐ P/T ☐ Hourly ☐ | Rotating Schedule? ☐ Yes ☐ No | Days Scheduled: (M-F, Sun-Thurs) _____ | # Hours/Day _____

Status (check one)

☐ Employee ☐ Volunteer ☐ Patient/Client ☐ Inmate ☐ Visitor

☐ Student (indicate school) _____

☐ Other: _____

Injury Information

If injured is Employee: | Occupation | Job Title | Soc. Sec. No.

Date of Injury/Exposure | Time Injury Occurred .AM/PM | Date Reported to Supervisor | Time Reported

Injury Reported To

Nature of Injury/Exposure (check all that apply)

☐ Fractures
☐ Inflammation
☐ Eye Injury
☐ Frostbite/Cold Exposure
☐ Heart Malfunction
☐ Electric Shock
☐ Multiple Injury
☐ Recurrence
☐ Inhalation Smoke
☐ Abrasions, Contusions, Bruises
☐ Burns
☐ Pinched Nerve, Ruptured Disk
☐ Strain, Sprain, Torn Ligament
☐ Cuts, Lacerations, Punctures**
☐ Heat Exhaustion, Fatigue
☐ Other : _____

**Also fill out Needlestick Form

☐ Chemical/Hazardous Material injury:
☐ Inhalation ☐ Ingestion ☐ Direct Contact
☐ Eye Injury ☐ Burns

☐ Chemical/Hazardous Material Injury:
☐ Infectious Disease

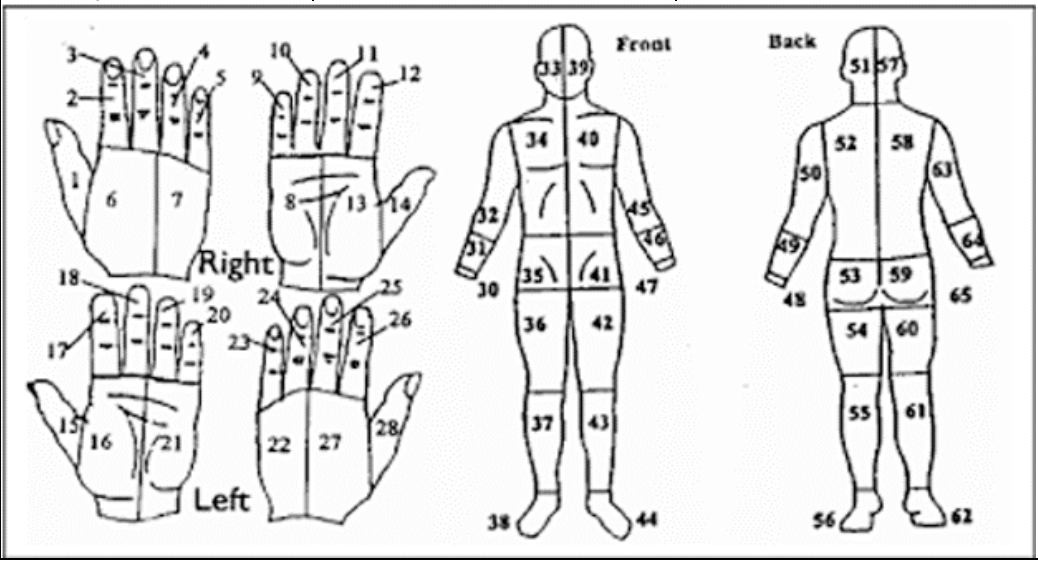
Parts of Body Affected (check all that apply and circle in diagram below)

☐ Right side of body
☐ Left side of body
☐ Multiple Parts

☐ Head ☐ Chest
☐ Eyes ☐ Lungs
☐ Ear(s) ☐ Abdomen
☐ Neck ☐ Back
☐ Shoulder ☐ Heart

☐ Groin
☐ Arm(s)
☐ Hand(s)
☐ Finger(s)
☐ Leg(s)

☐ Other (specify): _____



CATAWBA COUNTY INJURY/EXPOSURE REPORT
continued

Injury Information, cont'd

Where Injury Occurred (check all that apply) ☐ Station Maintenance ☐ Apparatus Maintenance ☐ Emergency Scene ☐ Search & Evidence Handling	☐ Fight or Assault ☐ Clinic/Lab ☐ Home Visit ☐ Group Home ☐ Client Outing ☐ Training	☐ Fundraising ☐ Convention ☐ Parade, Picnic, Contest ☐ Inspection Sites ☐ Auxiliary Services ☐ Standing by Station for Call	☐ Private Auto to Emergency ☐ Private Auto to Non-emergency ☐ Emergency Vehicle to Emergency ☐ Emergency Vehicle to Non-Emergency ☐ Responding to/Returning from Emergency ☐ Other _____
Cause of Injury (check all that apply) ☐ Weather ☐ Fall ☐ Struck by Object ☐ Structural Collapse	☐ Animal Attack ☐ Back Draft ☐ Horseplay ☐ Communication ☐ Abuse or Misuse ☐ Lifting	☐ Improper Placement ☐ Inadequate Illumination ☐ Inadequate Ventilation ☐ Lack of Knowledge or Skill ☐ Irrational Civilian/Patient ☐ Civil Disturbance	☐ Using Defective Equipment ☐ Using Equipment Improperly ☐ Making Safety Devices Inoperative ☐ Inadequate Guards or protection ☐ Failure to use Personal protection Equipment ☐ Other: _____

Injury Occurred Performing What Task?
(Employees, Students, Volunteers)

Safety Equipment Used (check all that apply)
☐ Gloves ☐ Mask ☐ Breathing Apparatus ☐ Protective Clothing ☐ Protective Eyewear ☐ Other: ☐ Sharps Collector

Witness	**Date**	**Signature of Injured**	**Date**
Witness	**Date**	**Completed by**	**Date**

Release of Medical Information

RELEASE OF MEDICAL/OFFICIALS INFORMATION

Name of Injured Employee (last, first, middle) **Date of Injury**

Date of Birth **SS#**

I, the above Injured Employee, authorize Catawba County to obtain verbal, handwritten or electronic communications pertaining to my injury from officials/medical providers.

Yes ___ No ___

If no, please state reason:

Signature of Injured Employee **Date**

Have supervisor fill out next section.

CATAWBA COUNTY INJURY/EXPOSURE REPORT

To be completed by Investigating Supervisor

Name of Injured/Exposed Person	DOB	SS#

Supervisor's Description of Incident Management

Thoroughly describe incident (what, how where, equipment activity, etc):

What first aid was administered following injury/exposure?

Was injured hospitalized or treated? ☐ Yes ☐ No	If Fatal, Date of Death (Mo/Day/Yr)
Where? Name Phone	By Whom? Name Phone
Address	Address

Was care offered and refused?

If injured is an employee, did injury result in requiring individual to perform limited duties or to be assigned to other duties?
☐ No ☐ YES: If yes, what duties were assigned?

	For what period of time?
Date employee injury was reported to Personnel Dept	To whom?

Completed by	**Title**	**Date**

Supervisor's Corrective Action Report

1. What acts, failures to act and/or conditions most directly contributed to this injury exposure (immediate cause)?

2. What are the basic or fundamental reasons for the existence of these acts and/or conditions?

3. What action has been taken or will be taken to prevent recurrence (✓ by items completed or implemented)?

Supervisor's Signature	**Title**	**Date**

Employee Signature	**Date**